Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: CHRISTUS ST JOHN HOSPITAL C/O HOLLOWAY & GUMBERT 3701 KIRBY DR STE 1288 HOUSTON TX 77098-3926	MFDR Tracking #: M4-06-3113-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: Service Lloyds Insurance Co. Box #: 42	Date of Injury: Employer Name: Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Requestor's Position Summary: "It is our position that the denial was neither fair nor reasonable pursuant to Rules 134.401(a)(4) and 134.600 of the Texas Workers' Compensation Commission ('TWCC'). Fees for goods and services provided by Christus St. John Hospital are based upon the rates that the market will bear in the geographic locale of the hospital… the prices which the hospital must charge for its goods and services are affected by, market forces beyond its control, including but not limited to the costs for raw materials, labor and transportation of goods and supplies… Fees are set based upon the cost factors described above, as well as the cost of maintaining the physical plant of the hospital, including but not limited to highly trained nursing and administrative personnel… charges for delivering the goods and services required to provide all patients with excellence in health care within Christus St. John Hospital reflect the costs associated with obtaining and maintaining hospital facilities, providing all necessary supplies, providing all necessary and modern equipment, as well as highly skilled personnel to provide the services required of a general hospital. Our client's rates for the goods and services it provides are similar to and competitive with other general hospitals in the greater Houston, Texas area… it is the position of Christus St. John Hospital that all charges relating to the admission… are due and payable as provided for under Texas law."

Principal Documentation:

1. DWC 60 Package
2. Medical Bill(s)
3. Medical Records
4. Total Amount Sought - $2,081.70

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Respondent's Position Summary: The respondent did not submit a position statement for review with the response.

Principal Documentation:

1. Response Package

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
8/13/2004-8/31/2004	No documentation of denial codes was submitted for review.	Outpatient Physical Therapy Services	$2,081.70	$0.00
			Total Due:	$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code §413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division rule at 28 Texas Administrative Code §134.1, titled *Use of the Fee Guidelines*, effective May 16, 2002 set out the reimbursement guidelines.

This request for medical fee dispute resolution was received by the Division on July 1, 2005. Pursuant to Division rule at 28 TAC §133.307(g)(3), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on January 13, 2006, to send additional documentation relevant to the fee dispute as set forth in the rule.

1. No explanations of benefits or documentation of denial codes were submitted for review with this request.
2. This dispute relates to outpatient physical therapy services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 TAC §134.401(a)(3), effective August 1, 1997, 22 TexReg 6264, which states that "Services such as outpatient physical therapy, radiological studies and laboratory studies are not covered by this guideline and shall be reimbursed at a fair and reasonable rate until the issuance of a fee guideline addressing these specific services."
3. Division rule at 28 TAC §134.1, effective May 16, 2002, 27 TexReg 4047, requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."
4. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
5. Division rule at 28 TAC §133.307(e)(2)(B), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires that the request shall include "a copy of each explanation of benefits (EOB)… relevant to the fee dispute or, if no EOB was received, convincing evidence of carrier receipt of the provider request for an EOB." Review of the documentation submitted by the requestor finds that the request does not include any EOBs for the disputed services. Neither has the requestor submitted convincing evidence of carrier receipt of the provider request for an EOB. The Division concludes that the requestor has failed to complete the required sections of the request in the form, format and manner prescribed under Division rule at 28 TAC §133.307(e)(1)(B).
6. Division rule at 28 TAC §133.307(g)(3)(A), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to send additional documentation relevant to the fee dispute including "documentation of the request for and response to reconsideration (when a provider is requesting dispute resolution on a carrier reduction or denial of a medical bill) or, if the carrier failed to respond to the request for reconsideration, convincing evidence of the carrier's receipt of that request." Review of the submitted evidence finds that the requestor has not provided documentation of the insurance carrier's response to the request for reconsideration or convincing evidence of the carrier's receipt of that request. The Division concludes that the requestor has not provided documentation sufficient to meet the requirements of Division rule at 28 TAC §133.307(g)(3)(A).
7. Division rule at 28 TAC §133.307(g)(3)(D), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:
   - The requestor's position statement asserts that "Fees for goods and services provided by Christus St. John Hospital are based upon the rates that the market will bear in the geographic locale of the hospital"; however the requestor did not discuss or submit documentation to support the rates that the market will bear in the geographic locale of the hospital.
   - The requestor's position statement asserts that "the prices which the hospital must charge for its goods and services are affected by, market forces beyond its control, including but not limited to the costs for raw materials, labor and transportation of goods and supplies"; however the requestor did not discuss or submit documentation to support its costs of raw materials, labor, or transportation of goods and supplies.
   - The requestor's position statement asserts that "Fees are set based upon the cost factors described above, as well as the cost of maintaining the physical plant of the hospital, including but not limited to highly trained nursing and administrative personnel"; however the requestor did not discuss or submit documentation to support the costs of maintaining the physical plant of the hospital, including highly trained nursing and administrative personnel.
   - The requestor's position statement asserts that "charges for delivering the goods and services required to provide all patients with excellence in health care within Christus St. John Hospital reflect the costs associated with obtaining and maintaining hospital facilities, providing all necessary supplies, providing all necessary and modern equipment, as well as highly skilled personnel to provide the services required of a general hospital"; however the requestor did not discuss or submit documentation to support the costs associated with obtaining and maintaining hospital facilities, providing all necessary supplies, providing all necessary and modern equipment, or employing highly skilled personnel to provide the services required of a general hospital.

- The requestor's position statement asserts that "Our client's rates for the goods and services it provides are similar to and competitive with other general hospitals in the greater Houston, Texas area"; however the requestor did not discuss or provide documentation to support the rates for goods and services provided by other general hospitals in the greater Houston area, or to support that its rates are similar to and competitive with those rates.
- The requestor did not submit documentation to support that the payment amount being sought is a fair and reasonable rate of reimbursement.
- The requestor does not discuss or explain how payment of the requested amount would ensure the quality of medical care, achieve effective medical cost control, provide for payment that is not in excess of a fee charged for similar treatment of an injured individual of an equivalent standard of living, consider the increased security of payment, or otherwise satisfy the requirements of Texas Labor Code §413.011(d) or Division rule at 28 TAC §134.1.
- Moreover, the Division has previously determined that a reimbursement methodology based on hospital costs does not produce a fair and reasonable reimbursement amount. This methodology was considered and rejected by the Division in the *Acute Care Inpatient Hospital Fee Guideline* adoption preamble which states at 22 *Texas Register* 6276 (July 4, 1997) that:

  "The Commission [now the Division] chose not to adopt a cost-based reimbursement methodology. The cost calculation on which cost-based models… are derived typically use hospital charges as a basis. Each hospital determines its own charges. In addition, a hospital's charges cannot be verified as a valid indicator of its costs…"

  "Therefore, under a so-called cost-based system a hospital can independently affect its reimbursement without its costs being verified. The cost-based methodology is therefore questionable and difficult to utilize considering the statutory objective of achieving effective medical cost control and the standard not to pay more than for similar treatment to an injured individual of an equivalent standard of living contained in Texas Labor Code §413.011. There is little incentive in this type of cost-based methodology for hospitals to contain medical costs…"
- Additionally, the Division has found that a reimbursement methodology based upon payment of the hospital's billed charges, or a percentage of billed charges, does not produce an acceptable payment amount. This methodology was considered and rejected by the Division in the same fee guideline adoption preamble as above which states at 22 *Texas Register* 6276 (July 4, 1997) that:

  "A discount from billed charges was another method of reimbursement which was considered. Again, this method was found unacceptable because it leaves the ultimate reimbursement in the control of the hospital, thus defeating the statutory objective of effective cost control and the statutory standard not to pay more than for similar treatment of an injured individual of an equivalent standard of living. It also provides no incentive to contain medical costs, would be administratively burdensome for the Commission and system participants, and would require additional Commission resources."

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Reimbursement is not recommended.

8. The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code sections §133.307(e)(2)(B), §133.307(g)(3)(A), and §133.307(g)(3)(D). The Division further concludes that the requestor failed to meet its burden of proof to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code § 413.011(a-d), § 413.031 and § 413.0311
28 Texas Administrative Code §133.307, §134.1, §134.401
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is not entitled to reimbursement for the services involved in this dispute.

DECISION:

	Grayson Richardson	**4/30/2010**
Authorized Signature	Medical Fee Dispute Resolution Officer	Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 TAC §148.3(c).

Under Texas Labor Code §413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.